MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF PERSONNEL

MEDICAL INFORMATION FOR WORK ADJUSTMENT/ACCOMMODATION REQUEST

Complete and submit to the Office of Personnel along with Work Adjustment/Accommodation Request (form PF-44). This information will be filed in employees' confidential medical files.

EMPLOYEE SECTION

By signing this form, I hereby authorize health care providers with information or documentation concerning this request for accommodation to release such medical records and provide any opinions concerning my ability to perform job-related functions, with or without reasonable accommodation, to the Department of Health and Senior Services.

EMPLOYEE NAME (PRINT)	EMPLOYEE SIGNATURE	DATE

SOCIAL SECURITY NUMBER	WORK LOCATION	WORK TELEPHONE NUMBER	JOB TITLE

HEALTH CARE PROVIDER SECTION

1. Is there a long-term (6 months or more) or permanent physical or mental impairment?

   ☐ Yes - What is the diagnosis?

   ☐ No - What is the expected duration?

2. What specific restrictions or limitations are imposed by the impairment(s)?

3. What are the job-related restrictions and what is the duration or expected duration of the restrictions?

4. What major life activity(ies) are substantially limited by the impairment?

5. What specific type(s) or kind(s) of assistance will enable the employee to perform the essential functions of his or her position?

PHYSICIAN NAME (PRINT)	PHYSICIAN SIGNATURE	DATE